DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Resource Based Relative Value Scale (RBRVS) Users:
- Anesthesiologists
- Advanced Registered Nurse Practitioners
- Emergency Physicians
- Family Planning Clinics
- Federally Qualified Health Centers
- Health Departments
- Laboratories
- Managed Care Plans
- Nurse Anesthetists
- Ophthalmologists
- Physicians
- Physician Clinics
- Podiatrists
- Psychiatrists
- Radiologists
- Registered Nurse First Assistants

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From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Subject: Physician-Related Services: Corrections and Updates

Unless otherwise specified, effective for dates of service on and after Apri1 1, 2005, the Medical Assistance Administration (MAA) will:

- Discontinue coverage for certain CPT codes;
- Clarify policy on certain injectable drugs and miscellaneous procedures;
- Update the prior authorization (PA) grid;
- Update the policy on portable X-rays (CPT codes R0070 and R0075);
- Update the list of services billable by podiatrists and orthopedic surgeons;
- Update the policy on immunization administration;
- Expand coverage for blepharoplasties;
- Discontinue coverage for certain HCPCS codes;
- Update place of service grid;
- Clarify policy on billing for contrast materials;
- Clarify policy on drug administration;
- Clarify policy on billing for ventilator management codes;
- Clarify billing policy for DDD physicals;
- Clarify coverage policy for tuberculosis treatment services provided by non-professionals;
- Cover additional podiatry codes as listed in this memorandum; and
- Cover PET scans with PA.

CPT Coverage Changes

The following procedures have been changed from covered to noncovered:

Procedure Code	Brief Description	Maximum Allowable Fee
29866	Autgrft implnt, knee w/scope	#
29867	Allgrft implnt, knee w/scope	#
29868	Meniscal trnspl, knee w/scpe	#
43257	Uppr gi scope w/thrml txmnt	#

Clarification of Coverage Policy for Certain Injectable Drugs

In certain circumstances, MAA limits coverage for some procedures and/or injectable drugs given in a physician's office to specific diagnoses or provider types only. This policy was outlined in previous memoranda. Although these memoranda were superseded, the policy regarding limited coverage for some procedures and/or injectable drugs remains in effect.

Limitations on coverage for certain injectable drugs are listed below:

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
J0637	Caspofungin acetate	117.3 (aspergillosis)
J0725	Chorionic gonadotropin/1000u	752.51 (Undescended testis)
J1055	Medroxyprogester acetate inj (depo provera)	Females-only diagnoses V25.02 or V25.3 or V25.49 or V25.9. (contraceptive mgmt) Males-diagnosis must be related to cancer
J1212	Dimethyl sulfoxide 50% 50 ML	595.1 (chronic intestinal cystitis)
J1595	Injection glatiramer acetate	340 (multiple sclerosis)
J1756	Iron sucrose injection	585(chronic renal failure)
J2324	Nesiritide	No diagnosis restriction. Restricted use only to cardiologists
J2501	Paricalcitol	585 (chronic renal failure)
J2916	Na ferric gluconate complex	585 (chronic renal failure)
J3420	Vitamin b12 injection	123.4, 151-154.8, 157-157.9, 197.4-197.5, 266.2, 281.0-281.3, 281.9, 284.0, 284.8-284.9, 555.9, 579, 648.2
J3465	Injection, voriconazole	117.3 (aspergillosis)
J3487	Zoledronic acid	198.5, 203-203.01, and 275.42 (hypercalcemia)
J9041	Bortezomib injection	203.00-203.01 (multiple myeloma and immunoproliferative neoplasms)

Corrected per IC-2005-3

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
Q3025	IM inj interferon beta 1-a	340 (multiple sclerosis)
Q3026	Suc inj interferon beta 1-a	340 (multiple sclerosis)
Q4077	Treprostinil, 1 mg	416-416.9 (chronic pulmonary heart disease)

Clarification of Coverage Policy for Miscellaneous Procedures

- Limitations on coverage for certain miscellaneous procedures are listed below:

Procedure Code	Brief Description	Limitation Restricted to ICD-9-CM
11980	Implant hormone pellet(s)	257.2 and 174-174.9
S0139	Minoxidil, 10 mg	401-401.9 (essential hypertension)
S0189	Testosterone pellet 75 mg	257.2, 174-174.9 and only when used with CPT code 11980

- **Verteporfin injections (HCPCS code J3396)**

  Effective for dates of service on and after January 1, 2005, the American Medical Association (AMA) deleted HCPCS code J3395 (verteporfin injections). This HCPCS code was replaced by HCPCS code J3396. MAA considers these injections to be medically necessary only when the diagnosis is 362.52 (exudative senile macular degeneration).

- **Collagen Implants**

Page	Reminder
G.8	MAA reimburses for CPT code 51715 and HCPCS code L8603 only when the diagnosis code is 599.82 (Intrinsic sphincter deficiency)

- **CPT code 88112**

Page	Reminder
E.19	MAA **does not** reimburse for CPT code 88112 when the diagnosis is V72.3 or V76.2.

Prior Authorization Grid Update

- The following procedure codes, erroneously included in the prior authorization (PA) grid in Numbered Memorandum 04-90 MAA, **do not require PA**: J7343, S0116, S2152, 97605, and 97606.

- The following codes were left out of the PA grid, **but do require PA**: J0180, J1931, J2357, S0158, S0159, and S0162. The complete PA grid is as follows:

Prior Authorization Grid for New Procedure Codes Covered as of January 1, 2005

19296	32019	78815	0079T	J1931
19297	43644	78816	0080T	J2357
19298	43645	79005	0081T	J7344
27412	43845	79101	0082T	S0158
27415	52402	79445	0083T	S0159
29866	58356	93745	0085T	S0162
29867	76510	0077T	0086T	S2082
31620	78814	0078T	J0180	S2083

Portable X-Rays

- Portable x-ray services furnished in a client's home or nursing facility and payable by MAA are limited to the following:

  - ✓ Skeletal films involving extremities, pelvis, vertebral column, or skull;
  - ✓ Chest or abdominal films that do not involve the use of contrast media; or
  - ✓ Diagnostic mammograms.

- To bill for transportation of x-ray equipment, bill the following:

  - ✓ R0070 - If there is only one patient bill one unit;

  - ✓ R0075 - If there are multiple patients, **bill one unit** per individual client's claim with one of the following modifiers, as appropriate. ***You must bill using a separate claim form for each MAA client seen.*** MAA reimburses the fee for procedure code R0075 divided by the number of clients, as outlined by the modifiers in table on the following page:

Procedure Code	Brief Description	April 1, 2005 Maximum Allowable Fee
R0070	Transport portable x-ray	$96.63
R0075-UN	Transport port x-ray multipl-2 clients seen	48.32
R0075-UP	Transport port x-ray multipl-3 clients seen	32.21
R0075-UQ	Transport port x-ray multipl-4 clients seen	$24.16
R0075-UR	Transport port x-ray multipl-5 clients seen	19.33
R0075-US	Transport port x-ray multipl-6 or more clients seen	16.11

☞ **Note:** MAA's reimbursement for procedure codes R0070 and R0075 includes setup. The fee for procedure code R0075 is divided among the clients served, as outlined by the modifiers indicated above. If no modifiers are used for HCPCS code R0075, the code will be denied. Do not bill HCPCS code R0070 in combination with HCPCS code R0075.

Updated Podiatric and Orthopedic Allowable Supplies

Retroactive to dates of service on and after January 1, 2005, MAA added the following services to those billable by podiatrists and orthopedic surgeons:

Procedure Code	Brief Description	1/1/05 Maximum Allowable Fee	
		NFS Fee	FS Fee
A5500	Diab shoe for density insert	$ 66.00	$ 66.00
A5501	Diabetic custom molded shoe	190.00	190.00
A5503	Diabetic shoe w/roller/rockr	33.00	33.00
A5504	Diabetic shoe with wedge	33.00	33.00
A5505	Diab shoe w/metatarsal bar	33.00	33.00
A5506	Diabetic shoe w/off set heel	32.00	32.00
A5507	Modification diabetic shoe (requires prior authorization)	A.C. Requires invoice if over $50.00	A.C. Requires invoice if over $50.00
K0628	Direct heat form shoe insert	33.50	33.50
K0629	Custom fab molded shoe inser	33.50	33.50

* For details on MAA's prior authorization process, refer to the Authorization Section (Section I) of MAA's current *Physician-Related Services Billing Instructions*

Immunizations and Administration

- ***Do not*** bill any of the codes in the following table in combination with CPT codes 90471-90472. MAA limits reimbursement for immunization administration charges to a maximum of two vaccines (e.g., one unit of 90465 and one unit of 90466; or one unit of 90467 and one unit of 90468).

CPT Code	Brief Description	1/1/05 Maximum Allowable Fee
90465	Immune admin 1 inj, <8 yrs (may not be billed in conjunction with 90467	$11.11
90466	Immune admin addl inj, < 8 yrs (must be reported in conjunction with 90465 or 90467)	6.57
90467	Immune admin O or N < 8 yrs (may not be reported in conjunction with 90465)	5.00
90468	Immune admin O/N, addl < 8 y (must be reported in conjunction with 90465 or 90467	3.00

☞ **Note:** MAA reimburses the above administration codes ***only*** when the physician counsels the client/family at the time of the administration and the vaccine **is not** available free of charge from the Health Department.

Clarification to Health Departments

Health Departments may bill CPT code 99211 when an immunization is the only service provided.

For example: If a client receives an immunization that is not available free of charge from the Department of Health (DOH), you may bill CPT code 99211, the appropriate immunization administration code(s) (i.e. 90471-90472 or 90465-90468), and the vaccine. If the vaccine was received at no charge from DOH, you may bill 99211 and the appropriate vaccine code with modifier –SL.

- On page C.10 of MAA's *Physician-Related Services Billing Instructions,* MAA incorrectly stated that CPT 90732 required PA. This CPT code **does not** require prior authorization.

- The following procedure code was inadvertently left unshaded in the EPSDT section (page C.10) of the *Physicians-Related Billing Instructions*:

Procedure Code	Brief Description
90702	Dt vaccine <7, im

- **Effective with dates of service on and after January 1, 2005,** MAA no longer covers CPT code 90659 and 90719. The AMA deleted these codes from the CPT manual.

Ventilator Management

CPT codes 94656, 94657, 94660, and 94662 for Ventilator Management are not billable with Evaluation and Management (E&M) services.

Blepharoplasties

CPT: 15822, 15823, 67901-67908, 67912
EPA # 870000630

MAA updated the expedited prior authorization (EPA) criteria and added the above bolded CPT codes for blepharoplasties for noncosmetic reasons as outlined below. MAA covers this procedure when one of the following applies:

- The excess upper eyelid skin impairs the vision by blocking the superior visual field;
- On a central visual field test, the vision is blocked to within 10 degrees of central fixation; or
- The procedure is needed for the correction of Lagophthalmos.

HCPCS Coverage Changes

Effective for dates of service on and after April 1, 2005, MAA will no longer cover the following HCPCS codes:

Procedure Code	Brief Description	Crosswalks effective January 1, 2005	Maximum Allowable Fee
S0016	Injection, amikacin sulfate	No crosswalk	Not Covered
S0158	Injection laronidase	J1931	22.74 (requires PA)
S0159	Injection agalsidase	J0180	121.12 (requires PA)
S8004	Wholebody radiopharm trgcell	None	Not Covered

Place of Service Update

MAA removed place of service code 20 from the Facility Setting grid on page J.2 of MAA's *Physician-Related Services Billing Instructions*. Place of service code 20 was erroneously included in the list.

Contrast Materials

MAA set maximum allowable fees for the following contrast materials for nuclear medicine procedures. Please note that these are **priced per milligram (mg)** unless otherwise stated**.** Units of service must reflect the milligrams given.

HCPCS Code	Brief Description	January 1, 2005 Maximum Allowable Fee
A4642	Satumomab pendetide per dose	$1,440.50
A4643	High dose contrast MRI	66.65
A4644	Contrast 100-199 MGs iodine	0.65
A4645	Contrast 200-299 MGs iodine	0.81
A4646	Contrast 300-399 MGs iodine	0.94
A9500	Technetium TC 99m sestamibi	110.17
A9502	Technetium TC99M tetrofosmin	108.36
A9503	Technetium TC 99m medronate	30.10
A9504	Technetium TC 99m apcitide	430.00
A9505	Thallous chloride TL 201/mci	30.08
A9507	Indium/111 capromab pendetid ***(Requires PA)***	1,984.45
A9508	Iobenguane sulfate I-131	1,032.00
A9510	Technetium TC99m Disofenin	51.60
A9511	Technetium TC 99m depreotide	688.00
A9512	Technetiumtc-99 mpertechnetate	12.24
A9513	Technetium tc-99m mebrofenin	46.57
A9514	Technetium tc99mpyrophosphate	39.56
A9515	Technetium tc-99m pentetate	25.46
A9516	I-123 sodium iodide capsule	116.27
A9519	Technetiumtc-99mmacroag albu	16.34
A9520	Technetiumtc-99m sulfur clld	64.50
A9521	Technetiumtc-99m exametazine	268.75
A9522	Indium111ibritumomabtiuxetan ***(Requires PA)***	2,045.89
A9523	Yttrium-90 ibritumomabtiuxetan ***(Requires PA)***	18,603.16
A9533	I-131 tositumomab diagnostic ***(Requires PA)***	2,322.00
A9534	Strontium-89 chloride ***(Requires PA)***	20,124.00
A9600	Samarium sm153 lexidronamm	872.15
A9605	Samarium sm153 lexidronamm	923.37

Billing Policy for DDD Physical Exam (HCPCS code T1023 with modifier HI)

MAA covers one DDD (Division of Developmental Disabilities) physical exam every 12 months for clients with disabilities. Providers must bill using:

- HCPCS code T1023 with modifier HI; and
- An ICD-9-CM diagnosis code from the following series: (V79.3 – V79.9).

Billing Policy for Tuberculosis (TB) Treatment Services

TB Treatment Services Performed by Non-Professional Providers: Health Departments billing for TB treatment services provided by **non-professional providers** in either the client's home or in the provider's office must bill using HCPCS code T1020 (personal care services). Do not bill the initial visit with a modifier. Follow-up visits must be billed using T1020 with modifier TS (follow-up services modifier).

Procedure Code	Brief Description	Maximum Allowable Fee
T1020	Initial visit	$35.87
T1020 TS	Follow-up	$21.37

New Codes added to the Podiatry/Orthopedic Section

The following codes will be added to the Podiatry/Orthopedic section.

Procedure Code	Brief Description	Maximum Allowable Fee
L1902	Boot-walkabout med/large	$73.68
L1906	Canvas ankle brace	90.53
L4350	Air support - purple med/large	74.10
L4360	Walker, pneumatic s-m-l	277.90 (Requires PA)
L4380	Aircast infrapatellar band	103.70
L4386	Diabetic walker	124.58 (Requires PA)

*For information on MAA's prior authorization or expedited prior authorization, please refer to section "I" of MAA's *Physician-Related Services Billing Instructions*.

PET Scans

MAA covers the following PET Scans with PA:

Procedure Code	Brief Description	Maximum Allowable Fee
G0330	Imaging, initial diagnosis cervical	B.R.
G0331	Pet imaging restage ovarian cancer	B.R.

Policy Clarification for Teaching Anesthesiologists

MAA reimburses teaching anesthesiologists for supervision of anesthesiology residents as follows:

- When supervising ***one*** resident only, the teaching anesthesiologist must bill MAA the appropriate anesthesia procedure code with **modifier AA**. Reimbursement to the teaching anesthesiologist will be 100% of the allowed amount.

- When supervising ***two or more*** residents concurrently the teaching anesthesiologist must bill MAA the appropriate anesthesia procedure codes with **modifier QK**. Reimbursement to the teaching anesthesiologist will be 50% of the allowed amount for each case supervised.

Drug Administration Policy Clarification

MAA does not reimburse for CPT code 99211 on the same date of service as drug administration codes G0345 – G0349, G0351 – G0353, and G0355 – G0362 , 90780 – 90788, 96400, 96408 – 96425, 96520, or 96530. If billed in combination, MAA will deny the E&M code 99211. However, providers may bill other E&M codes on the same date of service utilizing modifier 25 to indicate that a significant and separately identifiable E&M service was provided. If modifier 25 is not utilized, MAA will deny the drug administration code.

How can I get MAA's provider issuances?

To obtain MAA's provider numbered memoranda and billing instructions, go to MAA's web site at http://maa.dshs.wa.gov (click on the *Billing Instructions/Numbered Memoranda* or *Provider Publications/Fee Schedules* link).

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